Axial involvement in Psoriatic Arthritis: a multicentric analysis

Research team:

Catarina Abreu[1], Vanessa Fraga[1], Alice Morais Castro[1], Maria José Santos[1]

[1] Rheumatology Department, Hospital Garcia de Orta

Abstract:

Psoriatic Arthritis (PsA) is an heterogeneous inflammatory arthropathy associated with psoriasis and classified within the spondyloarthritis (SpA) group of diseases.[1,2] In 1973 Moll and Wright described 5 different types of PsA presentation: 1) asymmetric oligoarthritis; 2) symmetric polyarthritis; 3) predominant spondyloarthritis; 4) predominant distal interphalangeal joint involvement and 5) destructive arthritis[3], being symmetric polyarthritis the most common.[4]

The spinal involvement in PsA (axial Psoriatic Arthritis (axPsA)) can be exclusive, that is, without peripheral manifestations, or it can occur concomitantly with peripheral involvement. Actually, most patients with axPsA also have peripheral arthritis and axial involvement likely develops at a later stage in the course of PsA.[5] It is estimated that exclusive axial involvement occurs in 5% of patients and the prevalence concomitant with peripheral manifestations rises to 25-70%.[6-8] However, the absence of a consensus definition of axPsA makes it difficult to estimate its prevalence, study its characteristics, as well as the response to treatments. In the Corrona PsA registry the reported prevalence of axial disease based upon clinical judgment of the patient's treating rheumatologist was 12.5%. It is acknowledged that around 50% of patients may have subclinical spinal disease, by meeting the radiological criteria of the modified New York criteria for Ankylosing Spondylitis (AS), but without clinical manifestations.[9] The implications of this subclinical disease are unknown, although there may be differences in response to biologics when axial involvement prevails.

In an exploratory analysis of 132 patients with PsA followed in our department we found exclusive axial involvement and concomitant axial involvement with peripheral arthritis in 9% and 17%, respectively. In this cohort we identified male sex and HLA-B27 to be associated with axial involvement, while dactylitis and enthesitis were more common in patients with peripheral PsA.

Our aim is to estimate the prevalence of axial diseases in a larger cohort of patients with PsA and to understand how this diagnosis is made in clinical practice. Additionally, we intend to identify clinical characteristics (sex distribution, age at diagnosis, prevalence of extra-articular manifestations, HLA-B27 positivity, BMI and cardiometabolic comorbidities) associated with axPsA as well as treatments most frequently used.